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	345487	A. BUILDING _____ B. WING _____	C 11/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Recertification survey was conducted on 11/15/21 through 11/19/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 7HJI11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 11/15/21 through 11/19/21. Event ID# 7HJI11. Three of the 14 complaint allegations were substantiated resulting in deficiencies.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete and document a resident self-administration of medications for 1 of 1 resident reviewed for self-administration of medications (Resident #61). Findings included: Resident #61 was admitted to the facility on 10/29/21 with diagnoses which included non-Alzheimer's dementia and glaucoma. Resident #61's admission Minimum Data Set dated 11/04/21 revealed she was cognitively intact and required extensive assistance with	F 554	Affected Residents Resident #61 was discharged to home and is no longer a resident in the facility. Other Residents 100% of alert and oriented residents were interviewed by the QA Nurse on 11/30/21 regarding request to self-administer medications. All other residents who want to self-administer medications were assessed and reviewed by the Interdisciplinary team on 11/30/21 to ensure the right to self-administer meds is clinically appropriate. On 11/30/21 the MDS Nurse completed a	12/17/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/08/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 554	Continued From page 1 most activities of daily living. Record review indicated Resident #61 had no self-administration of medication assessment. Review of Physician's orders revealed no orders for medications to be kept at bedside. An observation on 11/15/21 at 3:32 PM revealed Resident #61 had tubes of over the counter medications lying on top of the bedside table. These tubes were: Cortisol (anti itch cream), Benadryl (anti itch cream), and Preparation H (hemorrhoid cream). An interview on 11/15/21 at 3:35 PM with the Director of Nursing revealed she was unaware of any resident at the facility who self-administered medications. She stated a self-administration assessment must be completed before a resident could keep medications at the bedside. An interview on 11/19/21 at 11:35 AM with the Administrator revealed that residents should be evaluated for self-administration of medications before they could be kept at bedside and he did not know why Resident #61 had medications in her room.	F 554	Self-Administration of Medication Assessment, care plans were updated and a physician order obtained as appropriate. All identified residents were provided with a lock box for medication storage by the DON on 12/2/21. Systemic Changes All residents and/or Resident Representatives will be notified on admission by the Admissions Director, via the admission packet, that no medications, even over the counter, can be kept in resident's room without a physician's order and an assessment must be completed to ensure self-administration of meds is clinically appropriate. 100% of nursing staff was inserviced on 11/17/21 by the Staff Development Coordinator regarding the policy for self-administration of meds including: a self- medication administration assessment must be completed; a physician order obtained and the care plan updated prior to any medication being left in a resident room. All medications being self-administered must be stored in a lock box and all medication at bedside must be removed if no physician order or assessment is present in the clinical record. All newly hired nurses will be inserviced on the process for Self Administration of Medication by the Staff Development Coordinator during orientation. QA Monitoring The QA Nurse will interview 10% of alert	

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F 554	Continued From page 2	F 554	and oriented residents weekly x 4 weeks and monthly x 1 month utilizing the Medication Self administration Audit Tool. This is to identify any new residents that want to self- administer medications to ensure the assessment is completed; a physician order obtained and the care plan updated. The physician will be contacted with any areas of concern and an assessment completed for all identified areas of concern. The DON will review the Medication Self administration tool weekly x 4 weeks and monthly x 1 month to ensure all areas of concern were addressed. The Administrator will present the Medication Self Administration Audit Tool to the Executive Quality Assurance Performance Improvement (QAPI) committee monthly x 2 months. The Executive QAPI Committee will meet monthly for 2 months and review the Medication Self Administration Audit Tools.	
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests,	F 561		12/17/21

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F 561	Continued From page 3 assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to assist a resident out of bed as requested and failed to provide showers as preferred and scheduled for 2 of 3 residents reviewed for choices (Resident #53 and Resident #23). Findings included: 1. Resident #53 was admitted to the facility on 10/19/2018 with a diagnoses of neck fracture. The annual Minimum Data Set (MDS) assessment for Resident #53 dated 10/22/2021 revealed he was cognitively intact. He required the extensive assistance of one person for transfers. He was dependent for bathing with one person assistance. It was somewhat important for him to choose between a tub bath, shower, bed bath or sponge bath.	F 561	Affected Residents Resident #53 received showers on 11/18 and 11/23/2021 by the assigned CNA and was out of bed with assistance on 12/7 and 12/8/21 by Therapy and the assigned CNA with documentation in the electronic clinical record. Resident #23 received showers on 11/16; 11/17 and 11/23/21 by the assigned CNA with documentation in the electronic clinical record. Other Residents On 11/22/21, the DON initiated an audit of showers for the past 7 days for all residents, to include resident #53 and resident #23. This audit is to identify any resident who was not offered a shower per facility protocol during the review	

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F 561	Continued From page 4 A review of the current care plan for Resident #53 revealed a focus area initiated on 10/22/2018 of daily and activity preferences related to glasses, bathing, snacks between meals, family involvement in care discussions, keeping up with the news revealed a goal last revised on 11/08/2021 of daily and activities preferences will be provided through next review. An intervention dated 10/22/2018 was bathing preference-evening shower. On 11/15/2021 at 12:11 PM an interview with Resident #53 indicated he had not been able to get out of bed when he wanted to on 11/14/2021. He stated this made him feel frustrated. He went on to say he asked his nursing assistant (NA #5) three times on 11/14/2021 to assist him with getting out of bed. Resident #53 further indicated each time he asked, his NA told him he was too busy and could not assist him. He went on to say after that, he just quit asking. A review of the November 2021 Documentation Survey Report for Resident #53 revealed transfers did not occur on 11/14/2021. On 11/17/2021 at 2:16 PM a telephone interview with NA #5 indicated he was assigned to care for Resident #53 on 11/14/2021 on the 7AM-3PM shift. He went on to say he did recall Resident #53 asking him for assistance to get out of bed. NA #5 stated he told Resident #53 he did not have time. He stated he was one of 3 NA's that day and he was assigned 20 residents to care for. NA #5 further indicated while he was able to provide incontinence care and feeding assistance for residents, he had not had time to assist Resident #53 out of bed.	F 561	period or who is not documented as refusing a shower. All areas of concern were immediately addressed by the assigned hall nurses and nursing assistants to include offering and providing residents with a shower or documenting 11/23;resident refusal of shower with notification of the Resident Representative (RR) of refusal if indicated. Audit was completed by 11/29/21. On 11/29/21, the DON initiated a Resident Preference Questionnaire with all alert and oriented residents to include resident # 53 and resident #23 in regards to preference for showers. The DON, MDS Nurse and Quality Assurance (QA) Nurse will address all concerns identified during the audit to include providing shower/bath/ADL care per resident preference and updating all care plans to reflect resident preference for bathing/ADL Care. Audit will be completed by 12/6/21 . On 12/6/21, the Scheduler updated the shower schedule to accommodate resident preferences. On 10/21/21 (and verified again on 12/2/21) the QA Nurse initiated interviews with all alert and oriented residents to include resident # 53 in regards to right to make choices to include getting out of bed. The Hall Nurses will ensure that residents' get out of bed per their choice with documentation in the electronic medical records, unless medically	

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F 561	Continued From page 5 On 11/16/2021 at 4:14 PM a follow up interview with Resident #53 indicated he had not been able to get a shower on the evening of 11/15/2021. He stated he waited and when no one came to assist him to shower he asked his nursing assistant (NA #6) about it. Resident #53 went on to say the NA told him she didn't have time because there weren't enough staff. A review of the November 2021 Documentation Survey Report revealed Resident #53 received a partial bed bath on 11/15/2021. On 11/17/2021 at 4:59 PM an interview with NA #6 indicated she provided care to Resident #53 on 11/15/2021 on the 3pm-11pm shift. She stated Resident #53 was scheduled for a shower that shift but she was assigned to care for 21 residents that day and she did not have time to provide a shower to Resident #53. She stated she assisted him with a partial bed bath instead. On 11/18/2021 at 10:58 AM an interview with Nurse #4 indicated she was working on 11/15/2021 on the 3PM-11PM shift. She stated there were 3 NA's that shift providing care to residents. She stated the NA's had 20 residents each to care for. She went on to say while Resident #53 had been assisted with a bed bath, the NA had not been able to provide his shower. Nurse #4 further indicated this had been an ongoing problem in the facility. She stated the facility had been trying to work with staffing agencies to get more help but it did not always work. On 11/18/2021 at 2:11 PM an interview with the Corporate Nurse Consultant (CNC) indicated the facility was aware residents had not been getting	F 561	contraindicated, for any identified areas of concern voiced during the interviews. Systemic Changes On 12/3/21 , the Staff Development Coordinator (SDC) initiated an in-service with all nurses and nursing assistants in regards to (1) Resident Preferences with emphasis on resident right to make choices about aspects of life to include but not limited to shower preferences and getting out of bed. (2) Resident Showers/ADL. In-services will be completed by 12/17/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Resident Preferences and Resident Showers/ADLs. QA Monitoring The MDS Nurse will audit ADL documentation of 10 residents to include resident #53 and resident #23 utilizing the Resident Care ADL Audit Tool. This will be completed weekly x 4 weeks then monthly x 1 month. This audit is to ensure all residents are offered/provided appropriate ADL care to include but not limited to showers/baths per resident preference and/or facility protocol, and ensure residents are getting out of bed per preference. Any areas of identified concern will be addressed by the hall nurse and nursing assistant to include providing resident care per preference, updating care plan/care guide of resident preference, notification of the resident representative of care refusals and/or	

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showers according to their preference. She stated on 10/20/2021 the facility put a performance improvement plan (PIP) in place to address the issue. The CNC went on to say since 10/21/2021 the facility had been in the monitoring phase of this PIP.

On 11/18/2021 at 2:27 PM an interview with the DON indicated the facility was aware that residents were not receiving showers according to their preference. She stated she was using the shower audit tool weekly according to the PIP to ensure showers were being done. She went on to say she had not completed the auditing for the week of 11/6/2021 through 11/13/2021 as she had not had time. The DON stated when the audits determined a resident had not received a shower per their preference, she addressed it with staff immediately.

On 11/19/2021 at 8:02 AM an interview with the administrator indicated residents should be receiving their showers according to their preference and assistance with getting out of bed when they wanted to because this was their right.
2. Resident #23 was admitted to the facility on 4/15/2021 with chronic respiratory failure.

The current care plan revised on 8/17/2021 addressed Resident #23's activities of daily living (ADL). The goal was all ADLs would be completed with staff support. The interventions included one person to provide physical assistance with bathing.

The Minimum Data Set assessment dated 9/23/2021 indicated Resident #23 was mildly cognitively impaired. The assessment revealed he required one-person physical assistance for

additional staff training. The DON will initial the Resident Care ADL Audit Tool weekly x 4 weeks, then monthly for one month to ensure all areas of concern were addressed.

The Director of Nursing will forward the Resident Care ADL Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the Resident Care ADL Audit Tool.

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baths. It further indicated there was no rejections of care during the look back assessment period.

During an interview with Resident #23 on 11/16/2021 at 10:00 am he stated he was not getting his showers like he was supposed to due to staffing. He further stated it happened in August 2021 and also on the previous Friday (11/12/2021) because the nurse aide (NA) was too busy.

A review of the shower schedule revealed Resident #23's showers were scheduled on Tuesdays and Fridays.

The shower documentation on the nurse aide ADL flowsheet for August 2021 was reviewed. The documentation indicated on 8/3/2021, 8/6/2021, 8/10/2021, and 8/13/2021 Resident #23 received partial baths. The November 2021 shower documentation indicate he had a partial bath on 11/12/2021 day shift and a full bath on the evening shift.

A review of the progress notes revealed there was no documentation in the progress notes about the shower not being provided on 11/12/2021.

During an interview with NA #2 on 11/16/2021 at 10:08 am she stated she was assigned to Resident #23 on 11/12/2021. She then stated she was unable to assist Resident #23 with his shower because she did not have enough time to help him because of low staffing. NA #2 stated she had informed Nurse #1 that he did not receive a shower.

On 11/16/2021 at 2:23 pm Nurse #1 stated she

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F 561	Continued From page 8 did not recall being told Resident #23 was not able to get a shower. She then stated she would have documented the reason in the progress notes. NA #2 worked with Resident #23 in August 2021 on the dates that he did not receive a shower. She stated during a telephone interview on 11/19/2021 at 8:18 am as far as she knew Resident #23 never refused a shower. She then stated if it was not documented on the NA activities of daily living flowsheet, he did not get the shower. NA #2 further stated staffing was low and she was unable to do the showers. She said Resident #23 really enjoyed his showers and would be very vocal when he did not receive it. The Director of Nursing stated on 11/19/2021 at 10:20 am the NA should have reported to the nurse that Resident #23 did not get his shower so the next shift could have assisted him with the shower. She further stated the facility was aware of the staffing issues.	F 561		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 656		12/17/21

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F 656	Continued From page 9 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to develop a comprehensive person-centered care plan for 1 of 1 resident (Resident #12) reviewed for respiratory care, who was diagnosed with chronic obstructive pulmonary disease and was receiving oxygen. Findings included:	F 656	Affected Resident Resident #12 – care plan was updated by the MDS Nurse with oversight from the Facility Nurse Consultant to include the COPD diagnosis and oxygen on 11/16/21 Other Residents All other residents with COPD diagnoses and oxygen orders were reviewed on	

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F 656	Continued From page 10 Resident #12 was admitted to the facility on 3-18-20 with multiple diagnoses that included chronic obstructive pulmonary disease. The quarterly Minimum Data Set (MDS) dated 9-1-21 revealed Resident #12 was severely cognitively impaired and was coded for oxygen use. Resident #12's care plan dated 9-8-21 revealed no goals or interventions for the resident's diagnosis of chronic obstructive pulmonary disease or the use of oxygen. Physician order dated 12-19-20 read; oxygen every shift as needed to maintain oxygen level greater than 90%. Resident #12's Medication Administration Record (MAR) for the month of November 2021 revealed the resident's oxygen level had fallen below 90% one time. Observation of Resident #12 occurred on 11-15-21 at 12:23pm. Resident #12 was observed receiving oxygen at 2 liters per minute by nasal canula. Observation of Resident #12 on 11-16-21 at 12:48pm revealed the resident was receiving oxygen at 2 liters by nasal canula. The MDS Nurse was interviewed on 11-16-21 at 4:00pm. The MDS nurse discussed usually care planning chronic obstructive pulmonary disease and stated she did not know why she had not for Resident #12. She further said, "I guess I missed it by accident." The MDS nurse stated she would	F 656	11/16/21 by the MDS Nurse with oversight from the Facility Nurse Consultant to ensure both COPD diagnoses and oxygen were on the care plan. All care plans were updated on 11/16/21 as appropriate. Systemic Changes The MDS Nurse was inserviced by the Nurse Consultant on 11/16/21 regarding the importance of ensuring all residents receiving respiratory care to include COPD diagnoses and oxygen administration are included on the Resident Care Plan. On 12/8/21, all nurses were inserviced by the Staff Development Coordinator on the expectation that any new interventions and/or diagnoses are to be included in the care plans. All newly hired nurses will be in-serviced by the Staff Development Coordinator, during orientation in regards to ensuring respiratory care is included in the care plans. QA Monitoring The QA Nurse will monitor 10% of residents receiving respiratory care weekly x 4 weeks and monthly x 1 month utilizing Respiratory Care Audit Tool. This is to ensure that all residents receiving respiratory care with a diagnosis of COPD or who are receiving oxygen are addressed on the care plan. Any issues or concerns will be addressed by QA Nurse completing audit by updating the care plan and/or retraining the MDS Nurse. The DON will review and initial the COPD	

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F 656	Continued From page 11 not care plan oxygen unless the resident had been receiving oxygen on a continuous basis. Nurse #1 was interviewed on 11-17-21 at 9:18am. The nurse stated Resident #12 had her oxygen on at 2 liters per minute all the time to maintain her oxygen level above 90%. Nurse #1 said she was aware the order read as needed and that she would discuss having the order changed with the physician. The Corporate Nurse Consultant was interviewed on 11-18-21 at 4:51pm. The Nurse Consultant stated she expected care plans to be accurate and Resident #12's diagnosis of chronic obstructive pulmonary disease and oxygen usage should have been care planned.	F 656	Diagnosis/Oxygen Tool weekly x 4 weeks and then monthly x 1 month to ensure all areas of concern have been addressed. The Director of Nursing will forward the Respiratory Care Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the Respiratory Care Audit Tool.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined	F 657		12/17/21

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F 657	Continued From page 12 not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to update a care plan for 1 of 1 resident (Resident #9) reviewed for smoking. Findings included: Resident #9 was admitted to the facility on 8/31/2020 with diagnoses that included cerebral infarction (stroke) and nicotine dependence. An admission smoking evaluation assessment dated 8/23/2020 indicated Resident #9 was a safe and independent smoker. The reassessment evaluation dated 7/30/2021 indicated Resident #9 was an unsafe smoker and required supervision. The annual Minimum Data Set assessment dated 8/23/2021 indicated Resident #9 was mildly cognitively impaired. The assessment revealed she had no behaviors and was a current tobacco user. She required limited assistance with transfers and used a wheelchair for mobility. It indicated Resident #9 had a functional limitation in range of motion on one side of the upper extremity. The current care plan reviewed on 8/23/2021 addressed Resident #9 was an independent and safe smoker or user of tobacco/tobacco	F 657	Affected Residents Resident #9's care plan was updated on 11/16/21by the MDS Nurse with oversight from the Facility Nurse Consultant to reflect that resident is a supervised smoker per the most recent Smoking Assessment. Other Residents On 11/16/21 the MDS Nurse conducted a 100% audit of smoking assessments, with oversight of the Facility Nurse Consultant to ensure care plans reflected each resident's smoking status (supervised vs. unsupervised). No other discrepancies between assessments and care plans were identified. Systemic Changes On 11/17/21, the SDC initiated an inservice for all nurses regarding ensuring that each resident's smoking status, whether supervised or unsupervised, is consistent with the smoking assessment and care plans and that any discrepancies should be reported to the Director of Nursing. All newly hired nurses will be inserviced	

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F 657	Continued From page 13 substitute product. The interventions included provide resident education on smoking policy, provide with a smoking apron, assist resident in obtaining smoking materials from secured storage area upon request, and may smoke independently without supervision. During an interview with the MDS Nurse on 11/16/2021 at 4:17 pm she stated she was unaware a new smoking evaluation had been completed for Resident #9. She then stated the Director of Nursing completed the evaluation and could have updated the care plan. She further stated the care plan should have been updated to reflect Resident #9' s need for smoking supervision. On 11/19/2021 at 10:30 am the Director of Nursing stated Resident #9's care plan should have been updated to supervised smoker. She then stated anyone could update the care plan, but the MDS Nurse was ultimately responsible for the care plan updates.	F 657	on the Smoking Policy, by the Staff Development Coordinator during orientation. QA Monitoring The SDC will monitor the most recent assessments and care plans for supervised and unsupervised smokers to assure all are consistent with each resident's smoking status. This will be done weekly for 4 weeks and then monthly x 1 month utilizing the Smoking Assessment Audit Tool. The care plan will be updated during the audit for any identified areas of concern and the nurse will be reeducated. The DON will review and initial the Smoking Assessment Audit Tool, weekly x 4 weeks and monthly x one month to ensure all areas of concern were addressed. The Director of Nursing will forward the Smoking Assessment Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly for two (2) months. The QAPI Committee will meet monthly for two (2) months and review the Smoking Assessment Audit Tools.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced	F 677		12/17/21

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F 677	Continued From page 14 by: Based on observation, record review, resident and staff interviews, the facility failed to provide Activities of Daily Living (ADL) care for 1 of 6 residents (Resident #1) who was dependent on facility staff for ADL care. Findings included: Resident #1 was admitted to the facility on 11-1-21 with multiple diagnoses that included fracture of the T11-T12 vertebra (lower part of the spine, thoracic area). The admission Minimum Data Set (MDS) dated 11-8-21 revealed Resident #1 was cognitively intact and needed extensive assistance with one person for toileting and personal hygiene. MDS also coded Resident #1 with adequate vision with corrective lenses. Resident #1's care plan dated 11-18-21 revealed a goal that the resident's ADL's/personal care would be completed with staff support as appropriate to maintain or achieve highest practical level of functioning. The interventions for the goal were in part; bathing-total dependance with one-person, personal hygiene/grooming extensive assistance. Resident #1 was interviewed on 11-15-21 at 10:20am. The resident stated he was not doing well. He explained he had been laying in his urine for almost 2.5 hours and had requested incontinence care at 8:00am. He stated the nursing assistant had come into his room and explained the facility was short staffed today (11-15-21) and that she would be back when she could. Resident #1 discussed therapy had been in	F 677	Affected Residents Resident #1 received incontinence care on 11/19; 11/20 and 11/21/21 by the assigned C.N.A. and is documented in the electronic health record. Other Residents On 11/29/21 a 100% audit of incontinence care for all residents to include resident #1 was completed by the Director of Nursing (DON), QI Nurse and Nursing Supervisor. This was to ensure incontinence care was provided to dependent residents and that residents were not saturated. Any identified concerns were immediately addressed during the audit. Systemic Changes On 11/30/21, the SDC nurse initiated a 100% inservice regarding the facility expectation of providing incontinence care to dependent residents so that residents are not saturated. The inservice will be completed by 12/17/21 QA Monitoring 10% observation of resident care to include incontinence care for all residents to include resident #1 will be completed by the DON, QI Nurse, SDC and MDS Nurse. This will be done weekly x 4 weeks then monthly x 1 month utilizing a Resident Care Audit Tool. This audit is to ensure dependent residents were provided incontinence care so that residents are not saturated. Any areas of identified concern will be addressed by the Director of Nursing. The DON will review and initial the Resident Care Audit	

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F 677	Continued From page 15 to see him but would not perform his therapy because he was soiled, and he is now afraid he had missed his therapy. He explained he had looked at the clock on the wall when he had asked the nursing assistant for help and that was how he knew how long ago it had been. He continued to discuss the facility's staffing and he stated, "this happens almost everyday but yesterday and today have been the worst." On 11-15-21 at 10:35am, this surveyor informed the Corporate Nurse Consultant of the situation with Resident #1. She explained she would inform the resident's nursing assistant. On 11-15-21 at 11:15am, this surveyor informed the Administrator of Resident #1's situation and prior conversation with the Corporate Nurse Consultant. The Administrator was observed requesting the nursing assistant care for Resident #1. Observation of incontinence care occurred on 11-15-21 at 11:20am with nursing assistant (NA) #1. Resident #1's brief was noted to be over saturated and had leaked onto the under pad beneath the resident. Resident #1 was noted to have redness to his peri area and buttocks that was blanchable. NA#1 was observed applying barrier cream to the resident's peri area and buttocks. NA #1 was interviewed on 11-15-21 at 11:38am. NA #1 confirmed Resident #1's brief had been soiled for several hours and the urine had leaked through to the under pad. She also confirmed the reddened areas on Resident #1's peri area and buttocks were not new. The NA discussed there were 3 nursing assistants today (11-15-21) and	F 677	Tools weekly x 4 weeks then monthly x 1 month to ensure all areas of concern have been addressed. The Administrator will present the findings of the Resident Care Audit Tools to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Resident Care Audit Tools to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 677	Continued From page 16 she was trying to do the best she could, and she stated, "I really can't provide the care the resident's need when we are so short staffed." Resident #1 was further interviewed on 11-16-21 at 12:53pm. The resident stated he had not received a bath or able to get out of bed on 11-15-21 but stated he had received incontinence care. Resident #1 further said he had received a bath and incontinence care right after breakfast this morning (11-16-21). During an interview with NA #2 on 11-16-21 at 1:15pm, the NA confirmed Resident #1 had not received a bath or placed in his chair on 11-15-21. She explained Resident #1 and 2 other residents were not able to receive a bath, get out of bed and had to wait more than an hour to receive incontinence care on 11-15-21. The Therapy Manager was interviewed on 11-18-21 at 3:41pm. The Therapy Manager stated Resident #1 had not missed any therapy sessions but that the physical therapist had to return several times before Resident #1 had been cleaned. She also stated the occupational therapist would be incorporating incontinence care into the therapy session. An interview with the Corporate Nurse Consultant occurred on 11-18-21 at 4:51pm. The Corporate Nurse Consultant stated the facility was not able to recuperate from the call outs on 11-15-21.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that	F 684		12/17/21

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F 684	Continued From page 17 applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, resident, staff and physician interviews, the facility failed to follow the facility's wound care protocol for 1 of 5 residents (Resident #12) by not providing wound care treatments to a skin tear for 4 days. Findings included: The facility's "Wound Care Manual" dated February of 2021 revealed a procedure for dressing application to a skin tear. The procedures read as follows; cleanse wound with normal saline or appropriate wound cleanser, apply a layer of Xeroform petroleum gauze or Hydrogel, cover with a dry dressing, wrap in place with gauze wrap if applicable, change every day or as physician indicated and as needed. Resident #12 was admitted to the facility on 3-18-20 with multiple diagnoses that included diabetes. The quarterly Minimum Data Set (MDS) dated 9-1-21 revealed Resident #12 was severely cognitively impaired and had no impairments to the skin. Resident #12's care plan dated 9-8-21 did not include goals and interventions for skin impairment.	F 684	Affected Residents The physician was contacted on 11/18/21 by the Treatment Nurse, with oversight from the Director of Nursing and a treatment order was obtained for the skin tear on Resident #12. The order was transcribed to the Treatment Administration record on 11/18/2021 by the Treatment Nurse. The Treatment Nurse changed the treatment on 11/18/21 with oversight from the Director of Nursing and documented the treatment on the Treatment Administration Record (TAR). Other Residents On 11/17/21, a 100% skin check audit and audit of TAR's of all residents was conducted by the DON and QA Nurse. This audit was to ensure there were no other residents with skin/wound treatments who did not have a physician order and to ensure all skin issues are being treated per order or wound care protocol/order and that all completed treatments are documented on the TAR. Systemic Changes On 11/18/21 a 100% in-service was initiated by the Staff Development Coordinator with all nurses in regards to Assessment and Notification of Skin	

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F 684	Continued From page 18 Resident #12's medical record was reviewed and revealed an incident report dated 11-12-21 documenting Resident #12 had a fall and sustained a skin injury to her left forearm but did not have any interventions for the skin injury documented. Review of Resident #12's Emergency Room report dated 11-13-21 revealed no orders for the skin injury to Resident #12's forearm. Resident #12's medical record had a nursing note dated 11-13-21 documenting Resident #12's return from the emergency room and the nurse's assessment of the resident. The documentation did not address Resident #12's left forearm. Physician orders were reviewed for the month of November 2021 and revealed no wound care orders for Resident #12's skin injury to her left forearm. Observation of Resident #12 occurred on 11-15-21 at 10:48 am. Resident #12 was observed to be non-communicative, laying on her back in the bed. A bandage was noted to be on Resident #12's left forearm with a date of 11-12-21. The bandage was intact but was observed to be blood soaked with dry brown edges on the bandage. A second observation of Resident #12 occurred on 11-16-21 at 12:48pm. The observation revealed Resident #12 had a bandage on her left forearm dated 11-12-21. The bandage was observed to be red in the middle with brown coloration over the rest of the bandage.	F 684	Issues with emphasis on dressing changes per physician or wound care protocol/order and that any treatment completed must be documented on the Treatment Administration Record. All newly hired nurses will be inserviced during orientation by the SDC regarding the facility Wound Care Protocol. QA Monitoring 10% review of residents to identify any new skin areas and that dressings are done per physician order will be completed by the QA Nurse. Weekly x 4 weeks then monthly x 1 month utilizing the Skin Audit Tool. This audit is to ensure all residents with any new skin tears/skin conditions were assessed and documented by nursing staff, the physician/RR was notified and an order was obtained for treatment to the area and that the dressings were completed per physician order and/or facility wound care protocol. The DON will review and initial the Skin Audit Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. The Administrator will present the findings of the Skin Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Skin Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 684	Continued From page 19	F 684		

Nurse #3 was interviewed by telephone on 11-17-21 at 9:32am. Nurse #3 stated she was working the evening of 11-12-21 when Resident #12 fell and received a skin injury to her left forearm. She explained the Wound Care (WC) Nurse at the facility had bandaged the residents left forearm prior to the resident going to the emergency room on 11-12-21.

Nurse #2 was interviewed by telephone on 11-16-21 at 5:50pm. The nurse confirmed she was the re-admitting nurse to the facility for Resident #12 on 11-13-21. She stated the resident did not come from the emergency room with any orders. Nurse #2 stated she assessed the resident and saw the bandage on the residents left forearm and thought she had documented it in her nursing note. She also explained she did not call the emergency room for orders or contact the facility physician for orders. She stated she left a communication for the physician in the physician's communication book to follow up with Resident #12 the next day.

Nurse #1 was interviewed on 11-17-21 at 9:18am. The nurse confirmed she was aware of a bandage on Resident #12's forearm but was not aware of any orders. She explained, if a nurse was alerted by a nursing assistant or the nurse saw a new wound, the nurse would open a flow sheet or leave a note at the nursing station for the Wound Care Nurse to assess. Nurse #1 further explained the Wound Care Nurse was responsible for writing the wound care orders.

A further observation of Resident #12 occurred on 11-17-21 at 9:25am. The observation revealed Resident #12 had a bandage on her left forearm dated 11-16-21. The bandage was observed to

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F 684	Continued From page 20 be clean with no red or brown areas observed. The Wound Care (WC) Nurse was interviewed on 11-17-21 at 11:40am. The WC nurse confirmed she had dressed Resident #12's skin injury to her left forearm on 11-12-21 prior to the resident going to the emergency room. She stated she used the skin tear protocol dressing Resident #12's injury with petroleum gauze and covering with a dry dressing. The nurse said she did not contact the physician or write an order because it was time for her to go home. She further added the nurse receiving Resident #12 back from the emergency room should have received an order. The WC nurse confirmed she changed Resident #12's dressing to her left forearm yesterday (11-16-21) without a physician order. The nurse explained Resident #12 should have had her dressing changed on 11-15-21 but stated since there was not an order written the nurse providing wound care on 11-15-21 did not know to perform wound care on Resident #12. The facility's physician was interviewed by telephone on 11-18-21 at 4:32pm. The physician discussed nursing staff having wound care protocols that they follow but was unaware of what wound care was completed for Resident #12. She also said she was not aware of wound care treatments not being completed on time due to a lack of orders but expected nursing to write orders per the wound care protocol. The Corporate Nurse Consultant was interviewed on 11-18-21 at 4:51pm. The Corporate Nurse Consultant stated she expected orders to be obtained prior to wound care being completed.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		12/17/21

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CHERRY POINT BAY NURSING AND REHABILITATION CENTER	110 MCCOTTER BOULEVARD HAVELOCK, NC 28532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 21 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interview, the facility failed to: 1) provide a redistribution/pressure relief mattress as indicated on the resident's care plan and failed to change wound treatment orders per facility protocol and 2) follow the physician orders for pressure ulcer prevention for 2 of 4 residents reviewed for pressure ulcers (Resident #4 and #58). Findings included: 1. Resident #4 was most recently readmitted to the facility on 11/05/21 with diagnoses which included Diabetes Mellitus and end stage renal disease. Resident #4 was out of the facility and in the hospital on 8/01/21 through 8/05/21 and 10/31/21 through 11/05/21. Resident #4's quarterly Minimum Data Set dated 8/11/21 revealed she was cognitively intact and	F 686	F686-D – Treatment/Services. To Prevent/Heal Pressure Ulcers Affected Residents A pressure relieving mattress was placed on Resident #4's bed on 11/19/21. On 11/22/21 Resident #4 asked to have mattress removed and refused any other alternatives. The Air mattress intervention was removed from care plan on 11/22/21 by the MDS Nurse. An order was received for a wound care consult on 11/18/21 for further orders/recommendations for wound healing and is scheduled for December 14th The Therapy Manager placed Resident #58 heel on the heel pillow on 11/18/2021 with documentation in the electronic medical record. Nurse Aide #7 was	

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F 686	Continued From page 22 required extensive assistance or total dependent for most activities of daily living. Further review revealed it was coded for 1 unstageable pressure ulcer. Review of wound ulcer flowsheet dated 8/06/21 revealed an unstageable right gluteal fold pressure ulcer with the current treatment of calmoseptine (a non-prescription skin cream that provides a barrier to prevent irritation from moisture and to promote healing) to skin. Review of Resident #4's care plan last revised on 11/10/21 revealed a focus for skin breakdown which included an intervention to place the resident on pressure relieving products such as pressure relieving mattress. Review of Resident #4's Treatment Administration Record (TAR) for August, September, October, and November 2021 revealed an order for Calmoseptine ointment to be applied to the right gluteal fold every day shift for unstageable right gluteal fold pressure ulcer. This treatment was signed as completed except when the resident was out of the facility. Review of the facility's wound care manual with the version date of February 2021 read in part that if there is no improvement in skin and wound problems in two weeks to a month, the patient should be reevaluated for a change in intervention. The manual further read that unstageable ulcer procedures for treatment included packing or covering the wound with debridement agents such as Santyl, antimicrobial impregnated gauze, or antibacterial agents. An interview on 11/17/21 at 12:04 PM with	F 686	inserviced by the Therapy Manager on 11/18/2021 regarding ensuring wound care interventions are in place per Resident Care Guide. Other Residents A 100% audit of care plans and Resident Care Guides was done by the MDS Nurse on 12/4/21 to ensure that any residents who are care planned for an air mattress and /or heel pillows have these in place. No further issues were identified. The QA Nurse completed a review of current Skin Assessments on 12/2/21 to ensure there was improvement with skin/wound problems within two weeks to a month (per policy). The QA Nurse will notify the physician, obtain order for wound clinic consult and/or provide changes in interventions for any identified areas of concern. Systemic Changes 100% inservice of nursing staff on 12/6/21 by the Staff Development Coordinator regarding reading the Resident Care Guide prior to starting care to identify any required preventative interventions and ensuring all care plan interventions are being followed specifically related to air mattresses and heel pillows/protectors On 12/2/21 the Facility Nurse Consultant inserviced the Treatment Nurse regarding notification of the physician for further orders and implementing additional interventions when there is no improvement with skin/wound problems	

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F 686	Continued From page 23 Resident #4 revealed she refused to have her wound care observed. She stated she was uncomfortable with people seeing the private areas of her body. An interview on 11/17/21 at 3:25 PM with the Wound Treatment Nurse revealed Resident #4's right gluteal fold wound was first noted on 12/28/20 and was previously resolved on 4/27/21 and subsequently reopened on 5/11/21. She stated the right gluteal pressure ulcer got better and then got worse and the resident had been in and out of the hospital. She stated she had tried other wound care treatments in the past but had not changed the current treatment since August 6, 2021. She stated she had not considered the wound clinic and that she should have referred the resident to the wound care clinic. An observation and interview with Nurse #1 on 11/18/21 at 2:52 PM revealed that Resident #4 was on a regular mattress. Nurse #1 confirmed Resident #4 was on a regular mattress. An interview on 11/18/21 at 4:30 PM with the Physician revealed she was aware that Resident #4 had a right gluteal fold pressure ulcer since December 2020. She stated the wound 'comes and goes'. She stated she did not know if the resident had a pressure relieving mattress or not and she was not involved in the decision for the resident to have a specialty mattress. The Physician stated the facility could have tried other treatments to heal her right gluteal fold pressure ulcer. An interview on 11/18/21 at 10:52 AM with the Director of Nursing revealed she was aware that Resident #4 had a right gluteal fold pressure but was unaware of why she did not have a specialty	F 686	within two weeks to a month (per policy). QA Monitoring All new ordered equipment, to include air mattress and heel protectors, will be discussed by the Administrative team during the Cardinal Clinical Meeting 5 x week. The QA Nurse, MDS Nurse, Staff Development Coordinator and Treatment Nurse will attend the meeting and ensure the equipment has been implemented and care planned. The QA, MDS Nurse and Staff Development Coordinator will audit 100% of residents who are care planned to have an air mattress and/or heel pillows/protectors weekly x 4 weeks then monthly x 1 month utilizing the Skin Audit Tool. This audit is to ensure that all residents who are care planned to have an air mattress and/or heel pillows have them in place. The DON will review the audits weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed. C.N.A. and/or Hall Nurse will be retrained by the QA Nurse on any identified areas of concern. The QA, MDS Nurse, and SDC will audit 10% of current Skin Assessments to ensure there was improvement with skin/wound problems within two weeks to a month(per policy) utilizing the Skin Audit Tool. This will be done weekly x 4 weeks and monthly x 1 month. The Treatment Nurse will be inserviced and physician notified on any identified areas of concern. The DON will review the audits weekly x 4 weeks then monthly x 1 month to ensure	

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F 686	Continued From page 24 mattress or why her wound care treatment had not been changed since August 6, 2021. An interview on 11/19/21 at 10:14 AM with the Staffing Development Coordinator (SDC) revealed she was unable to locate any documentation that Resident #4 had ever tried or refused a specialty mattress. She also stated the facility had a specialty mattress and it would be placed on the resident's bed that afternoon. An interview on 11/19/21 at 11:35 AM with the Administrator who stated the facility should provide the appropriate equipment and wound care protocols to ensure the resident had the necessary care for wound healing. 2. Resident #58 was admitted to the facility on 1/28/2021 with diagnoses that included dementia without behavior disturbances. The care plan initiated on 1/28/2021 and last revised on 11/02/2021 addressed a potential for skin break down related to incontinence and high risk for pressure ulcer. The interventions included place on pressure relieving devices as appropriate, staff to report to nurse any reddened or open areas, do not massage over any bony areas, if nutritional status deteriorates, arrange a dietary consult, inspect skin, and notify nurse of abnormal changes, lubricate skin with moisturizing lotion, and air mattress. Another care plan initiated on 11/2/2021 addressed interference with structural integrity of layers of the skin. The interventions included turn and reposition routinely, bridge heels, heel pillow to heels and feet, and ensure specialty mattress is in place. The current significant change Minimum Data Set	F 686	all areas of concern were addressed. C.N.A. and/or Hall Nurse and Treatment Nurse will be retrained by the QA Nurse on any identified areas of concern The Administrator will present the findings of the Skin Audit Tools to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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(MDS) assessment dated 10/27/2021 indicated Resident #58 was severely cognitively impaired. She required extensive assistance with all activities of daily living and had no functional limitation in range of motion. The assessment was not coded for pressure ulcers.

A review of the progress note dated 10/28/2021 revealed a significant change was completed due to decrease in functional mobility and weight loss.

A review of a nursing note dated 11/1/2021 revealed a darkened area was observed on Resident #58's right heel.

The review of the diagnoses list revealed pressure induced deep tissue damage of the right heel was added on 11/1/2021.

A review of a physician order dated 10/20/2021 revealed air mattress and check setting every day. Another order dated 11/1/2021 revealed heel pillow to bilateral feet while in bed for pressure reduction and barrier film to right heel pressure ulcer every day shift.

The Resident care guide intervention that was initiated on 11/2/2021 revealed for heel protection use a heel pillow.

A review of the dietician note dated 11/4/2021 revealed Resident #58 weight was stable for the last month, down 10 pounds (lbs.) within the last 3 months, and down 13 lbs. within the last 6 months. The note indicated she had a decreased intake of 25 percent per nursing documentation and an evaluation was requested for speech therapy. It revealed Resident #58 received a nutritional supplement twice a day, vitamins, and

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a protein supplement to aid in healing of her right heel suspected deep tissue injury (SDTI).

Observations on 11/15/2021 at 10:00 am, and 2:46 pm revealed Resident #58 was resting in bed with her eyes closed. The heel pillow was on the wheelchair during the observations. Her heels were on the bed mattress.

Observations on 11/16/2021 at 9:00 am, 12:00 pm, and 2:30 pm revealed Resident #58 was resting in bed and did not have the heel pillow under her feet. The heel pillow was on the chair in her room.

During an interview with nurse aide #7 at 11/16/2021 at 2:30 pm she stated she did not work with Resident #58 on a regular basis and was unaware she needed to have a heel pillow. She stated she could look at the care guide in the computer to find out if a resident needed special equipment or the nurse would inform her of any special needs. She further stated she did not look at the care guide for Resident #58 and Nurse #6 did not report that she needed a heel pillow.

An interview with Nurse #6 on 11/16/2021 at 2:40 pm revealed she was aware Resident #58 was to have a heel pillow while in bed. She further stated she had not been in the room lately and did not notice that the heel pillow was not under her feet.

A review of the Treatment Administration Record for the month of November 2021 revealed for heel pillow to bilateral feet while in bed and air mattress pressure checks were initialed up to the current date of 11/16/2021. All the blanks for heel treatment were also initialed daily.

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F 686	Continued From page 27 On 11/19/2021 at 10:00 am during an interview with the Director of Nursing she stated Resident #58's heel pillow should have been under her feet while she was in the bed as ordered. She further stated the nurse aides were aware to check the care guide daily for changes.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to provide ambulation (walking) as specified in the comprehensive plan of care for 1 of 3 residents reviewed for range of motion (Resident #53). This placed Resident #53 at risk for a decline in his ability to ambulate. Findings included:	F 688	Affected Residents Resident #53 received ambulation per plan of care on 11/20; 11/21; 11/23; 11/24; 12/1 and 12/2/2021 with documentation in the clinical record. Other Residents On 12/1/21, The MDS Nurse completed a 100% audit of care plans of residents that	12/17/21

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Resident #53 was admitted to the facility on 10/19/2018 a diagnoses of neck fracture.

The annual Minimum Data Set (MDS) assessment for Resident #53 dated 10/22/2021 revealed he was cognitively intact. He required the extensive assistance of one person for transfers. Walking in his room and the corridor with one person assistance occurred only once or twice during the assessment period. He was not steady during walking and was only able to stabilize with staff assistance. He used a walker and a wheelchair (WC) for mobility.

The current comprehensive care plan for Resident #53 revealed a focus area initiated on 11/17/2020 of requires assistance to maintain maximum function of self-sufficiency for mobility related to at risk for decline in ability to ambulate. The goals last revised on 11/08/2021 were for Resident #53 to maintain the ability to ambulate up to 300 feet on even surfaces using a rolling walker and for him to participate in the restorative program through the next review. An intervention was ambulation program: ambulate up to 75 feet on even surfaces using rolling walker with limited assistance 6 x week, document the reason if he did not participate in the restorative ambulation program, and report to the nurse any changes in his abilities.

A review of the nursing restorative summary for Resident #53 dated 10/21/2021 at 4:02 PM revealed he was ambulating 75ft with contact guard assist and a rolling walker with a WC to follow. The goal in restorative was to maintain the ability to walk 75 feet. Resident #53 maintained his ability to ambulate the required distance during the review period. No decline in endurance

require ambulation and compared with the nurse aid documentation for ambulation provided. All issues were addressed by the MDS Nurse during the audit.

Systemic Changes
100% inservice for nursing staff regarding documentation of and providing ambulation per the care plan was conducted on 12/6/21 by the Staff Development Coordinator. Nursing staff was also instructed that, if a Restorative C.N.A. is not available on a particular shift that ambulation is scheduled, it is the responsibility of each resident's C.N.A. to ensure that ambulation is provided and documented as outlined in the care plan. All newly hired nursing staff will be inserviced by the Staff Development Coordinator during orientation regarding ambulation being provided per care plan.

QA Monitoring
The MDS Nurse will review documentation of all residents who require ambulation per the care plan weekly x 4 weeks then monthly x 1 month utilizing the Ambulation Documentation Tool . This audit is to ensure that all residents who are care planned to receive ambulation are receiving ambulation and that it is documented as having been done. Nurse aide will be retrained on any identified areas of concern. The DON will review and initial the Ambulation Documentation Tool weekly x 4 weeks then monthly x 1 month to ensure all areas of concern were addressed.
The Administrator will present the findings

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F 688	Continued From page 29 was noted. A review of the Restorative Nursing flowsheet documentation for Resident #53 from 11/4/2021 though 11/17/2021 revealed no documentation he participated in the restorative ambulation program on 11/5/2021, 11/9/2021, 11/10/2021, 11/12/2021, 11/13/2021, 11/14/2021, 11/15/2021, and 11/17/2021. A review of Resident #53's medical record did not reveal any refusals of restorative ambulation from 11/4/2021 through 11/17/2021. On 11/15/2021 at 12:11 PM an interview with Resident #53 indicated he was not receiving the walking assistance he should be. He stated staff were supposed walk with him several times a week and they were not. He went on to say he hadn't asked about this because staff were supposed to know to walk with him. He stated he did not think his ability to walk had declined but he worried if staff continued not walking with him, it would. On 11/17/2021 at 2:41 PM an interview with the MDS nurse indicated she coordinated the restorative nursing program. She stated Resident #53 was not receiving restorative ambulation 6 times weekly as recommended because when there were not enough nursing assistants (NA) available, either no one was assigned to work as the restorative aide or the restorative aide was pulled off that assignment to provide care to residents. She went on to say this had been an ongoing issue in the facility. On 11/17/2021 at 2:56 PM a telephone interview with NA #4 indicated she was frequently assigned	F 688	of the Ambulation Documentation Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Ambulation Documentation Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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as the restorative aide including on 11/09/2021. She stated she was pulled off her assignment as the restorative aide when there were not enough NA's to provide care to residents and no one replaced her.

On 11/18/2021 at 2:49 PM an interview with Nurse #1 revealed she was familiar with Resident #53 and frequently assigned to his care on the 7AM-3PM shift. She stated restorative ambulation often did not get done because when there were not enough nursing assistants (NA) to provide care to residents no one was assigned as restorative aide or the restorative aide was pulled off that assignment to work on the floor. She went on to say it had been an ongoing issue in the facility. Nurse #1 stated she could do things like apply splints for residents when she was administering medication but something like ambulation just was not going to happen.

On 11/18/2021 at 5:31 PM an interview with the director of nursing (DON) indicated she was aware there were days from 11/04/2021 through 11/17/2021 when no one was assigned as the restorative aide. She stated she was also aware there were days during that same period when the assigned restorative aide was pulled off the restorative aide assignment to provide care to residents. The DON went on to say there had not been enough staff to provide Resident #53 with restorative ambulation during this period because NA's were busy providing other care to residents. She further indicated on the hierarchy of needs restorative ambulation just did not get done.

On 11/19/2021 at 8:28 AM an interview with the administrator indicated it was unacceptable that Resident #53 was not receiving his restorative

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F 688	Continued From page 31 ambulation as recommended because the facility did not have enough staff to provide this.	F 688		
F 725 SS=D	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews the facility failed to provide sufficient staffing to assist a resident out of bed as requested (Resident #53) , provide showers as	F 725	On 11/19/21, the Administrator reviewed the assignments sheets for the upcoming 3 days to ensure there are adequate nursing assistant staff scheduled to meet	12/17/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	Continued From page 32 preferred and scheduled (Resident #53 and Resident #23) , provide ambulation as specified in the comprehensive plan of care (Resident #53) and provide Activities of Daily Living (ADL) care for a resident (Resident #1) who was dependent on facility staff for ADL care. This affected 3 of 23 residents reviewed for staffing. Findings included: This tag is cross referenced to: F561 Based on record review and resident and staff interviews the facility failed to assist a resident out of bed as requested and failed to provide showers as preferred and scheduled for 2 of 3 residents reviewed for choices (Resident #53 and Resident #23). F677 Based on observation, record review, resident and staff interviews, the facility failed to provide Activities of Daily Living (ADL) care for 1 of 6 residents (Resident #1) who was dependent on facility staff for ADL care. F688 Based on record review and resident and staff interviews the facility failed to provide ambulation (walking) as specified in the comprehensive plan of care for 1 of 3 residents reviewed for range of motion (Resident #53). This placed Resident #53 at risk for a decline in his ability to ambulate. On 11/19/2021 at 8:10 AM an interview with Nurse #6 indicated prior to 10/28/2021 she served as the NA scheduler. She stated she used the budgeted NA hours table to create the schedule 30 days in advance. She stated she would then manage call outs and needs daily and	F 725	the staffing requirements and needs of the residents. The Administrator and scheduler addressed all concerns identified during the audit. On 11/19/21, The Administrator reviewed agency contracts to ensure the facility has multiple agencies to choose from during staff concerns. The purpose of the agency service is to fill open on duty aide positions to meet staffing requirements and meet the needs of the residents. The facility is currently utilizing Florence, Favorite, Titan, Excel, and Maxim. To ensure availability of contracted staff, the facility has additionally reviewed contract staff assignments in place of prn agency staffing when available. The facility has consistently been placing ads on Indeed for posting of job openings. The advertisements for nursing assistants and/or nurse assistant trainees have consistently been running since February 2021. The ads are re-initiated every 14-21 days. On 11/22/21, the scheduler began validating nursing assistant staff schedule 24 hours prior to each scheduled shift to ensure the staff schedule is accurate and to confirm staff attendance. The scheduler will notify the Director of Nursing and/or Administrator of all staffing concerns so that agency or administrative staff can be used to fill vacancies. On 11/22/21, the Scheduler/SDC (and Manager on Duty on weekends) will begin confirming staff attendance each shift to ensure the facility has at least the minimum requirements to provide personal care and supervision according	

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F 725	Continued From page 33 update the schedule. Nurse #6 further indicated facility staff were required to call out 2 hours before their scheduled shifts but agency staff were not. She stated she would do her best to fill vacant shifts and call outs but it was sometimes not possible. She stated it was also very difficult to get an agency staff replacement the same day. She went on to say the facility was having staffing issues and at times did not have the staff they needed based on the census. She stated the facility had been offering a significant financial bonus for staff to pick up extra shifts but staff were getting burned out. On 11/19/2021 at 9:31 AM an interview with the NA #8 indicated she began serving as the NA scheduler on 10/28/2021. She stated she used the budgeted NA hours table to create the 30 day schedule. She went on to say at times it was very stressful. NA #8 stated that on 11/14/2021 the census was 62 residents which called for 8 NA's, however, the facility only had 3 from 7AM-3PM. She further indicated when she was not able to find anyone else to come in, she put herself down to work the shift. NA #8 went on to say she did not work that 7AM-3PM shift because she needed to work from 3PM-11PM that day. She stated the 3PM-11PM shift called for 6 NA's and there was only 1 available. She further indicated she and the second NA had been able to meet only the basic needs of the residents that shift. NA #8 stated now call outs were oftentimes not replaced. She further indicated she provided the director of nursing and the administrator a list of staff needs for each staffing schedule and posted this needs list at the time clock and in the staff break room. On 11/19/2021 at 9:59 AM an interview with the	F 725	to local state and federal regulations and codes. The Scheduler/SDC (and Manager on Duty on weekends) will immediately notify the Director of Nursing and/or Administrator of all staffing concerns. Administrator/DON will contact agencies and/or reach out to sister facilities to ensure staffing is adequate. On 11/22/21, the SDC initiated an in-service with all nurses and nursing assistants in regards to Staffing with emphasis on notification of Administrator and DON when the facility does not have adequate staff to meet the needs of the residents so that Administrator/DON can contact agencies and/or reach out to sister facilities to cover any vacancies to ensure staffing is adequate. In-service will be completed by 11/26/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Staffing. The Scheduler and SDC will review the upcoming schedule and staffing assignment sheets for staffing needs weekly x 4 weeks then monthly x 1 month utilizing the Staffing Audit Tool to ensure the facility has minimum requirements to provide personal care and supervision according to local state and federal regulations and codes. The scheduler will ensure that off duty staff and/or agency are contacted when there is a vacant assignment. The Administrator will review the Staffing Audit Tool weekly x4 weeks then monthly x 1 month to ensure all concerns addressed. The Administrator will forward the results of the Staffing Audit Tool to the Executive	

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F 725	Continued From page 34 DON indicated staffing was a daily struggle. She stated the facility currently had 4 full time 7AM-3PM NA vacancies, 4 full time 3PM-11PM NA vacancies, 1 full time 11PM-7AM vacancies, and 4 part time NA vacancies for each shift. She went on to say the facility had a performance improvement plan (PIP) in place to address the issue. She further indicated the facility was still not meeting its daily staffing targets which were based on budgeted staff hours and the facility census. The DON went on to say the facility had not reevaluated the PIP. On 11/19/2021 at 8:02 AM an interview with the administrator indicated the facility utilized the facility assessment, daily census, and budgeted NA hours table to determine staffing needs. He stated the facility had a PIP in place to address the staffing problem. He went on to say the facility was also utilizing agency staff. He further indicated the facility was still not meeting it's targeted staffing numbers even with agency staff. The administrator stated the facility had not reevaluated the PIP.	F 725	Quality Assurance Performance Improvement (QAPI) committee monthly for 2 months. The Executive Quality Assurance Performance Improvement (QAPI) committee will meet monthly for 2 months and review the Staffing Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F 812		12/17/21

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F 812	Continued From page 35 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to label and date food items stored in the resident nourishment refrigerator. This was for 1 of 1 resident nourishment refrigerators reviewed for food storage. This practice had the potential to affect food served to residents. Finding included: On 11/18/2021 at 11:32 AM an observation of the resident nourishment refrigerator with Nurse #1 revealed one brown paper takeout food bag with no name or date containing individually wrapped takeout food items that were unlabeled and undated, one white plastic bag with two white cardboard takeout food containers with metal handles with no name or date, one white plastic bag with two clear plastic food storage containers with red lids containing food, labeled with a resident's name but undated, and one white cardboard takeout food container with a metal handle with no name or date. An interview with Nurse #1 at that time indicated this nourishment refrigerator was for the storage of resident items only. She stated all resident food items placed in this nourishment refrigerator should be labeled with the resident's name and dated when placed in the refrigerator. Nurse #1 stated these items should be discarded within 3 days. She further	F 812	All unlabeled and undated food was removed from the nourishment refrigerator by the Nurse Consultant on 11/18/21. The refrigerator was rechecked on 11/19/21 by the Facility Nurse Consultant, to ensure there was no unlabeled or undated foods. There was no areas of concern identified. 100% of staff was inserviced on 11/18/21 in regards to prior to placing any resident food in the nourishment refrigerator, it must be labeled and dated. All newly hired staff will be inserviced by the SDC regarding checking the refrigerator for undated//unlabeled food in the refrigerator. 11p-7a nurses were reinserviced by the DON on 11/19/2021 and will continue to check the Nourishment Refrigerator on a daily basis to ensure there are no unlabeled/undated items. QA Monitoring The Dietary Manager will check the nourishment refrigerator weekly x 4 weeks	

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F 812	Continued From page 36 indicated she could not say for sure how long the items had been in the refrigerator, because they were undated. On 11/18/2021 at 11:49 an interview with the Dietary Manager (DM) indicated the facility had one nourishment refrigerator for the storage of resident food items. She stated all resident food items placed in this refrigerator should be labeled with the resident's name and dated when placed in the refrigerator. The DM went on to say these items should then be discarded within 3 days due to the potential for spoilage and nutrient loss. On 11/18/2021 at 12:49 PM an interview with the Director of Nursing (DON) indicated the facility had one nourishment refrigerator for the storage of resident food items. She stated this refrigerator was only accessible by facility staff. She went on to say staff should label food items with the resident's name and the date when the items were placed in the refrigerator. She stated this refrigerator was accessed multiple times daily by staff and any staff accessing the refrigerator should be monitoring for unlabeled, undated food items. The DON further indicated unlabeled, undated food items food items should not be in the resident nourishment refrigerator. She went on to say food items placed in the resident nourishment refrigerator should be discarded within three days. On 11/18/2021 at 12:57 PM an interview with the Administrator indicated any food items placed in the resident nourishment refrigerator should be labeled with the residents name and dated. He stated food items placed in the resident nourishment refrigerator should be discarded within 3 days.	F 812	and monthly x 1 month to ensure there are no unlabeled items utilizing the Nourishment Refrigerator Audit Tool. All unlabeled/undated food will be removed during the audit and staff retrained by the Dietary Manager. The Administrator will review and initial the Nourishment Refrigerator Audit Tool weekly x 4 weeks and monthly x 1 month to ensure all areas of concern were addressed. The Administrator will present the findings of the Nourishment Refrigerator Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Nourishment Refrigerator Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted	F 842		12/17/21

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F 842	Continued From page 38 by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on record review, observations, staff and physician interviews, the facility failed to (1) document wound care treatments, (2) discontinue wound care treatment orders after the wound was resolved and (3) staff continued to document treatment was provided to a wound that was healed. This occurred for 2 of 5 residents (Resident #12 and Resident #26) reviewed for wound care. Findings included:	F 842	Affected Residents The physician was contacted on 11/18/21 by the Treatment Nurse and a treatment order was obtained for the skin tear on Resident #12. The order was transcribed to the Treatment Administration record on 11/18/21 by the Treatment Nurse. Resident #26, wound treatment order was clarified by the resident MD on 11/17/21 with an order obtained by the Treatment to	

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F 842	Continued From page 39 1.Resident #12 was admitted to the facility on 3-18-20 with multiple diagnoses that included diabetes. The quarterly Minimum Data Set (MDS) dated 9-1-21 revealed Resident #12 was severely cognitively impaired. The MDS did not indicate coding for skin issues. Resident #12's care plan dated 9-8-21 did not include goals and interventions for skin impairment. Observation of Resident #12 occurred on 11-15-21 at 10:48am. Resident #12 was observed to be non-communicative, laying on her back in the bed. A bandage was noted to be on Resident #12's left forearm with a date of 11-12-21. The bandage was intact but was observed to be blood soaked with dry brown edges on the bandage. Resident #12's medical record was reviewed and revealed an incident report dated 11-12-21 documenting Resident #12 had a fall and sustained a skin injury to her left forearm. The medical record did not have any assessment or nursing notes documenting what type of skin injury or what treatment was rendered. Review of physician orders for the month of November 2021 revealed no orders to treat a skin tear to Resident #12's left forearm. Resident #12's Treatment Administration Record (TAR) was reviewed for the month of November 2021 and revealed no documentation of a treatment being performed on Resident #12's left	F 842	discontinue the treatment. The Treatment Nurse discontinued the treatment from the treatment administration record on 11/17/21 per the physician's order. Other Residents On 11/19/21, the QA Nurse completed an audit of all wounds/skin assessments for the last 30 days to ensure that any identified resolved wounds had a discontinue order and that the order had been discontinued from the treatment administration record. The Treatment Nurse and QA Nurse completed 100% head to toe assessment on all resident to ensure that all identified skin abnormalities to include wounds and skin tears have been addressed. Any concerns will be reported to the MD for clarification order and an Incident Report will be initiated for any documentation concerns. Systemic Changes An inservice was initiated with all nurses on 11/18/21 by the Staff Development Coordinator (SDC). regarding not signing off on a treatment order unless the treatment was actually completed. The inservice will be completed by 12/17/21. All newly hired nurses will receive both inservices by the SDC during orientation. Facility Nurse Consultant inserviced the Treatment Nurse on 12/1/21 regarding: 1) All wound treatments must have a physician order and documented on the	

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F 842	Continued From page 40 forearm. Observation of Resident #12 on 11-17-21 at 9:25am revealed the bandage on Resident #12's left forearm had been changed with a date on the bandage of 11-16-21. The Wound Care (WC) Nurse was interviewed on 11-17-21 at 11:40am. The WC Nurse explained she was present on 11-12-21 when Resident #12 fell, and she had applied petroleum gauze (wound dressing) covered with a dry dressing to Resident #12's left forearm. She confirmed she did not document Resident #12's injury in the medical record but stated she had followed the facility's wound care protocol. The nurse also confirmed she had changed Resident #12's bandage on 11-16-21 using petroleum gauze covered with a dry dressing. The WC nurse stated she had not contacted the physician to obtain an order for further wound care to be completed or documented in Resident #12's medical record the dressing change she preformed on 11-16-21. The facility's Medical Director was interviewed by telephone on 11-18-21 at 4:32pm. The Medical Director stated she was not aware that Resident #12 had a wound on her forearm until 11-18-21 when the WC Nurse had called her for further wound care orders. She also said she expected the nurse caring for Resident #12 to have received and written the wound care orders. 2. Resident #26 was most recently readmitted to the facility on 10/15/21 with diagnoses which included hypertension and non-Alzheimer's dementia. Resident #26's quarterly Minimum Data Set dated 11/03/21 revealed she had moderately impaired	F 842	TAR when provided 2) Once a wound has resolved the order should be discontinued and set up for monitoring when appropriate and 3). Ensuring treatments are not documented as being completed on once the area is resolved. The inservice will be completed by 12/1/21. QA Monitoring The Quality Assurance nurse will monitor all Weekly Assessments for new and resolved skin issue to ensure there is a physician order for all new issues and that treatments are being documented and that the order has been discontinued for any resolved skin issues utilizing the Skin Audit Tool. The Director of Nursing will review and initial the Skin Audit Tool weekly x 4 weeks and monthly x 1 month to ensure all areas of concern were addressed. The Administrator will present the findings of the Skin Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Skin Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	

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F 842	Continued From page 41	F 842		

cognition and required extensive assistance or totally dependent for most activities of daily living. She was coded to have 3 stage 2 pressure ulcers and 1 deep tissue injury present on readmission.

Review of Resident #26's wound ulcer flowsheets dated 11/11/21 revealed the lower coccyx stage 2 pressure ulcer was resolved.

Review of the November 2021 Treatment Administration Record (TAR) for Resident #26 revealed an order which read to apply barrier cream to lower coccyx pressure ulcer daily and with perineal care every day shift. This order was signed as completed on November 12 through 16, 2021 by the Wound Treatment Nurse (on 11/12 and 11/16), Nurse #5 (on 11/13 and 11/14) and Nurse #3 (on 11/15).

An interview on 11/17/21 at 3:55 PM with the Wound Treatment Nurse revealed she was responsible for wound care orders. She stated Resident #26's lower coccyx stage 2 pressure wound had healed, and the treatment order should have been discontinued on 11/11/21. She stated she was too busy and had forgotten to discontinue this order. She confirmed she had signed Resident #26's lower coccyx pressure ulcer wound care as completed on November 12 and 16. She confirmed she had not completed this order and stated she did not know why she had signed that she completed it.

An interview on 11/18/21 at 10:10 AM with Nurse #5 revealed she was responsible for providing wound care treatments. She confirmed she had not completed the wound care treatment for Resident #26 on November 13 and 14 and stated she did not know why she had signed it as

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F 842	Continued From page 42 completed. An interview on 11/18/21 at 10:52 AM with the Director of Nursing revealed she was unaware that Resident #26's wound care orders had not been discontinued when the wound was resolved or why the nurse had signed wound care orders as completed when they had not completed the treatment. She stated she was concerned to learn that the wound care nurses had signed orders as completed without doing them after the wound had been documented as resolved. An interview on 11/19/21 at 11:35 AM with the Administrator revealed that he believed nurses should not sign orders as completed unless they had performed them.	F 842		